CMDIR
congenital muscle disease international registry

Medical Release Form: Important – Please Read

On the reverse side of this form, please complete information about your or your child's medical providers, including:

1. Genetic Testing Laboratory (if testing was sent to an outside lab)
2. Muscle/Skin Biopsy Pathology Laboratory (if testing was sent to an outside lab)
3. Primary Care Doctor/Pediatrician*****
4. Neurologist*****
5. Pulmonologist*****
6. Cardiologist*****
7. Orthopedist*****
8. Otolaryngologist (ENT)*****
9. Hospital(s)
10. Clinic(s)

***If multiple providers are seen at the same facility, please only list the facility name and not each individual provider.**

You may leave the fax number fields blank so that we can be sure to identify the correct number for medical records. If you know the medical records department's fax number, you can include it.

If you require more space for providers, please complete a second form.

By law, we are required to state on the medical release form that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. Please understand that we will not release your or your child's identifying information to anyone without your express permission. We may release extracted medical data for the purposes of research and education in a manner that is deidentified and in aggregate with other participant data in the registry.

If you have any questions, do not hesitate to contact us by phone at: **(562) 444-5656 x103,** or by email at: **records@cmdir.org**.

Congenital Muscle Disease International Registry (CMDIR) Authorization to Release Patient Medical Records

Cure CMD | 3217 E. Carson St. #1014 | Lakewood, CA 90712 USA | Phone: (562) 444-5656 x103 | Fax: (310) 684-2023 | Email: records@cmdir.org

*****Digital Records Are Always Preferred Over Paper*****

The following individual has been registered in the CMDIR and authorizes release of medical records as indicated below					
First Name:	Middle Name:	Last Name:	Date of Birth:	Last 4 digits of SSN:	Gender: ☐ M ☐ F

I authorize the following healthcare providers to release my/my child's medical records:

Provider, Clinic, Lab, or Hospital Name	City, State/Province Country if outside the U.S.	MR/ID# (if known)	Dates of Service (From and To)	Contact Numbers
				Medical Records/Provider Phone:
				Medical Records Fax:
				Medical Records/Provider Phone:
				Medical Records Fax:
				Medical Records/Provider Phone:
				Medical Records Fax:
				Medical Records/Provider Phone:
				Medical Records Fax:

I authorize release of the following records:

- ☐ **Genetic Testing – Patient**
- ☐ **Genetic Testing – Parent**
- ☐ **Muscle/Skin Biopsy Pathology Report(s)**
- ☐ **Pulmonary Function Test Report(s)**
- ☐ **Sleep Study Report(s)**
- ☐ **Echocardiogram & EKG Report(s)**
- ☐ **Lab Results (e.g. CK/CPK, Liver Function)**
- ☐ **Imaging Report(s) (MRI, X-Ray, CT)**
- ☐ **DEXA/Bone Density Scan Report(s)**
- ☐ **EMG/Nerve Conduction Report(s)**
- ☐ **Perinatal Records**
- ☐ **Admission/Discharge Summaries**
- ☐ **Encounter/Clinic Notes**
- ☐ **Growth Chart(s)**
- ☐ **Autopsy Report (if applicable)**

I authorize the above named provider(s) to release information that exists in the patient's medical record to the CMDIR when the form is signed, as well as information created after the form is signed for **one year (365 days)**. I may withdraw my permission at any time by providing written notice to the above-named providers releasing the information. If I withdraw my permission, any information that was already released cannot be retrieved.

I understand that authorizing the disclosure of this protected health information is voluntary and that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I understand my authorization will not condition treatment, payment, enrollment, or eligibility for benefits, however may condition enrollment in clinical studies initiated through the CMDIR. The CMDIR will curate all records received, confirming diagnosis and medical issues as well as evaluate eligibility for clinical studies.

Signature: _____ Date: _____

Printed Name: _____ Phone: _____ Relation to Patient: ☐ Self ☐ Parent/Legal Guardian